

PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
Patient Employed By _____ Occupation _____
Home Phone _____ Work/Mobile phone _____
Whom may we thank for referring you? _____
In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birth date _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Ins. ID No. _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Birth date _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Ins. ID No. _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

I give permission for treatment of myself/my dependent to my assigned provider.

Responsible Party Signature

Relationship

Date